APPLICATION FOR RESPIRATORY CARE PROFESSIONAL LICENSURE

ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

AP NUMBER	_____	**FILE NUMBER**	_____
RECEIVED	_____	**COMPLETED**	_____
TEMP PERMIT #	_____	**DATE ISSUED**	_____
LICENSE NUMBER	_____	**DATE ISSUED**	_____
WITHDRAWN	_____	**DATE WITHDRAWN**	_____
DENIED	_____	**DATE DENIED**	_____

ALL FEES ARE NONREFUNDABLE*

F E E S A R E S U B J E C T T O C H A N G E

_____Applying for 12-month permit
_____Applying for 18-month permit
_____Applying for Reciprocity

APPLICANT INFORMATION

I hereby make application for certification pursuant to the Georgia Respiratory Care Practice Act (O.C.G.A. 43-34-140) and submit the following statement concerning my age, moral character, education and practice.

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the National Practitioner's Data Bank (NPDB) or other state medical boards or regulatory agencies for license tracking purposes.

☐ **I do <u>not</u> wish this information to be released to the NPDB, other medical boards, or other regulatory agencies for license tracking purposes.**

PLEASE TYPE OR PRINT LEGIBLY.

2. LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	PLACE OF BIRTH

☐ **I am a U.S. Citizen**

☐ **I am <u>not</u> a U.S. Citizen, but am a qualified alien under the Federal Immigration and Naturalization Act, and I am lawfully present in the United States. (IF YOU CHECKED THIS BOX, SEE CHECKLIST REQUIREMENTS FOR SUBMITTING SUPPORTING DOCUMENTATION)**

3. Mailing address – This address will be used to mail application status information.

STREET NUMBER	STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		@
(AREA CODE) HOME PHONE NUMBER	(AREA CODE) WORK PHONE		E-MAIL ADDRESS

4. If you were born outside of the US, how long have you lived in the US? _____YEARS _____MONTHS

5. Have you served in the armed forces?	IF YES, DATES OF SERVICE (MM/DD/YY – MM/DD/YY)
☐ Yes ☐ No ☐ Not applicable	_____
6. Have you been discharged?	IF YES, DATE OF DISCHARGE (MM/DD/YY)
☐ Yes ☐ No ☐ Not applicable	_____ TYPE OF DISCHARGE **(ATTACH A COPY OF YOUR DISCHARGE FORM)** _____

☐ **7. Are you certified/registered by the National Board of Respiratory Care?** _____Yes _____No

APPLICANT QUESTIONNAIRE		
INSTRUCTIONS: If you answer, "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and official disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application.	**YES**	**NO**
1. Has any board or agency denied issuance of or pursuant to disciplinary proceeding refused renewal of certificate?	❑	❑
2. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (If yes, provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	❑	❑
3. Have you ever been arrested for and/or convicted of a violation of any Federal (including military), State or Local statute?	❑	❑
4. Have you ever been denied the privilege of taking an examination given by any state licensing Board or been denied a certificate/license?	❑	❑
5. Has any state licensing Board revoked or suspended a certificate/license issued to you or taken other disciplinary action?	❑	❑
6. Have you ever been denied membership in any professional society or association?	❑	❑
7. Have you had any malpractice suits filed against you?	❑	❑
8. Have you ever voluntarily surrendered any professional license or certificate?	❑	❑
9. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑
10. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
11. Have you ever been dismissed or resigned while under investigation at a hospital?	❑	❑
12. Have you ever defaulted on child support payments?	❑	❑
13. Did you include a copy of your CV or résumé with this application packet?	❑	❑
14. Date you began working as a Respiratory Therapist in Georgia? DATE:_____/_____/_____		

RESPIRATORY CARE LICENSES

Record below the State(s) where you hold or have held a license to practice **Respiratory Care:**

❑ N/A

State	Date License was Issued Month/Year	License Status (Circle One)
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive
		Active Inactive

RESPIRATORY CARE AND OTHER HEALTH RELATED LICENSES

Record below the State(s) where you hold or have held license to practice **any other** health related profession.

❑ N/A

State	Type of License	Date License was Issued Month/Year	License Status (Circle One)
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive
			Active Inactive

EDUCATION

<u>INSTRUCTIONS</u>: Provide the name of your respiratory care program and dates of attendance. For Respiratory Care education and other education, indicate all beginning and ending months and years of attendance. All gaps in the chronological progression of your training must be explained on a separate piece of paper, i.e., leave of absences, sabbaticals, taking a year off to work in order to pay for the next year of training, etc.

RESPIRATORY CARE EDUCATION:

SCHOOL NAME:	**DATES OF ATTENDANCE:** **FROM**(MONTH)__________(YEAR)________ **TO** (MONTH)________(YEAR)________
CITY AND STATE:	

☐ **N/A**

OTHER EDUCATION: (USE ADDITIONAL SHEETS, IF NECESSARY)

SCHOOL NAME:	**DATES OF ATTENDANCE:** **FROM**(MONTH)__________(YEAR)________ **TO** (MONTH)________(YEAR)________
CITY AND STATE:	**TYPE OF DEGREE AWARDED:**

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